WEST VIRGINIA INSURANCE COMMISSI0N

APPLICATION FOR
CERTIFICATION AS AN EXTERNAL REVIEW ORGANIZATION
☐ New Certification ☐ Renewal Certification

Company Information

Legal Name			*Federal Employer ID NO.*
DBA/Trade Name			
Business Address	*City*	*State*	*Zip*
Mailing Address	*City*	*State*	*Zip*
Telephone	*Fax*	*E-Mail Address*	
Name of Executive Officer			
Contact Person	*Telephone*		
List states in which applicant is incorporated, licensed, certified or otherwise authorized to conduct business:			

I hereby attest to the accuracy of this application

_____
Signature of CEO

Sworn and subscribed to before me this _____day of _____, 20____

_____*My commission expires*_____
Notary Public

GENERAL INSTRUCTIONS:

Send the completed application to:

Legal Division
West Virginia Insurance Commission
PO Box 50540
Charleston, WV 25305-0540

1. **REGISTRATION WITH THE WEST VIRGINIA SECRETARY OF STATE**

The applicant must be licensed to do business with the West Virginia Secretary of State.

Secretary of State
State Capitol Complex
Building 1, Suite 157-K
1900 Kanawha Blvd. East
Charleston WV 25305-0770
Phone (304) 558-6000

2. Respond to all questions, including attachments, in consecutive order. Submit all requested information. Note: False or misleading statements will result in the loss of certification and/or other action/penalty.

3. Do not alter the forms provided by the West Virginia Insurance Commission. We will supply the proper form and answer any questions that you may have.

4. Certification must be renewed every two years.

5. No entity may submit an application if it owns or controls, is a subsidiary of or in any way owned or controlled by, or exercises common control with, any of the following: a health benefit plan; a state or local trade association of health care providers; or a national, state, or local trade association of health benefit plans.

6. For questions regarding the certification process please contact:

The Legal Division (304) 558-0401

SECTION A

Please submit the materials listed below in the following order and check each item, as it is included. Identify each attached response with reference to the appropriate roman numeral and letter to which it refers:

I. Organizational Structure:

Check List	*Materials Requested*
	A. Certificate of Incorporation and Certificate of Authority to do Business in West Virginia.
	B. Policies and Procedures that govern all aspects of the operation of the organization and process's to review and update the policies and procedures.
	C. Organizational chart showing all lines of authority within a holding company or parent company and subsidiary.
	D. List and describe the scope and relationship of all agreements between the applicant and health care service entities, health care providers and management service organizations.
	E. Procedures in place to ensure that no compensation of anything of value other than payment for fees and cost of external review, shall be accepted, permitted, or provided by or to the external review organization

II. Management of the External Review Organization:

Check List	*Materials Requested*
	A. Job descriptions including the responsibilities and process for evaluation and assessment for the staff.
	B. Formal training programs.
	C. Confidentiality policies.
	D. Process to ensure compliance with Federal and State laws as well as any accrediting body that has given certification.
	E. Provide names and biographies of all directors, officers and executives of the External Review Organization.

III. Quality Management:

Check List	***Materials Requested***
	A. Policies that show Reviews will be conducted in the time frames specified by the **West Virginia Legislative Rule Title 114, Series 58**.
	B. A policy for the process by which selection of qualified and impartial clinical peer reviewers to conduct the external review on behalf of the Organization for specific cases is handled.
	C. A description of a copy of any policy ensuring that all employees of the External Review Organization adhere to the requirements of the **West Virginia Legislative Rule Title 114 Series 58.**
	D. A description of a copy of any policy procedure to ensure that clinical peer reviewers assigned to review a particular appeal do not have a prohibitive conflict and process to notify the West Virginia Insurance Commissioner of such a conflict should it arise.
	E. A description of a copy of any policy procedures to prevent and identify any conflict of interest in all areas of the Organization.
	F. A description of a copy of any policy that allows for any pertinent additional information to be provided by the plan or the member for standard or expedited review.

IV. Clinical Peer Reviewers/Contracted Clinical Peer Reviewers:

Check List	***Materials Requested***
	A. Names of each reviewer and include current state license number(s), clinical discipline(s) expertise, current board certifications, history of any sanctions and/or disciplinary actions, potential conflicts of interest and research focus where applicable.
	B. Procedures to ensure that the clinical peer reviewers are trained and in compliance with external review requirements and trained in the principles, procedures and standards of the External Review Organization.
	C. Evidence that there is no involvement with the case prior to review or any other conflict of interest.

V. External Review Process:

A description or copy of any policy showing how the external review process will be managed including a showing of the following:

Check List	***Materials Requested***
	A. No party other than the external review organization shall control, directly or indirectly, the appointment of clinical peer reviewers to an external review;
	B. The clinical peer reviewer has the expertise in the treatment of the medical condition of the enrollee and clinical experience in the past three years with the proposed health care service at issue;
	C. The clinical peer reviewer has an unrestricted license by the state in the United States in which the clinical peer is licensed;
	D. The clinical peer reviewer has not been disciplined or sanctioned by a hospital or government entity based on the quality of care provided by the clinical peer;
	E. In the case of the physician be certified by a nationally recognized medical specialty board in the area that is the subject of the review;
	F. A Description and or a chart that diagram the sequence of steps through which the external review will move from the receipt of the external review by the certified external review agent through notification to the enrollee, the health plan and the Insurance Commissioner regarding the external review determination;
	G. Procedures for ensuring that the clinical peer reviewers, when making an external review determination, shall consider safety, efficacy, appropriateness and cost effectiveness. All the Information provided by the enrollee, the medical record, attending physician's recommendations and information used by the managed care plan to make their determination. They shall also take into consideration findings, studies, research, and other relevant documents of government agencies and nationally recognized medical professional organizations, including the National Institutes of Health or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, the United States Food and Drug Administration, the Center for Medicare and Medicaid Services of the United States Department of Health and Human Services, and the Agency for Health Care Policy Research and Quality. Also any relative findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical experts, and clinical guidelines adopted by relevant national medical societies and the terms of coverage under the enrollee's managed care plan;
	H. Policies that show process of notification of external review process that indicates what is done when the external review is terminated.

VI. Reporting Requirements:

Check List	*Materials Requested*
	A. A report or policies that require records to be retained for a three-year period;
	B. A report to the West Virginia Insurance Commissioner by the 31st day of March each year for the preceding calendar year. The report required will be in the aggregate, for each managed care plan, and for West Virginia external reviews only. The report is to include: 1.____The total number of request for the external reviewer; 2.____The number of request resolved and of those resolved, the number resolved upholding the adverse determination and the number resolved reversing the adverse determination; 3.____The average length of time for a standard external review and for expedited external reviews; 4.____A summary of the types of coverage's or cases for which an external review were sought and the types of health care plans involved in the external review; 5.____The number of external reviews that were terminated at the request of the managed care plan as a result of reconsideration by the managed care plan, except those external review terminated because the enrollee and/or their treating provider presented as part of the external review information that has not been provided to the plan prior to the external review; 6.____Any other information the Insurance Commissioner of West Virginia may request or require.

VII. Financial Statement:

Submit audited financial statements for the External Review Organizations most recently completed fiscal year prepared on a generally accepted accounting basis including: assets, liabilities, and net worth; the results of operations; and the changes in net worth for the fiscal year on the accrual basis.

SECTION B

INSTRUCTIONS: Section B should be duplicated and forwarded to each of the following individuals for completion: All Directors, executives, Medical Director and all owners.

An affidavit that must be completed by each individual listed above is included. Without all signed and notarized affidavits this application will be considered incomplete.

Omission of any information requested may lead to exclusion of the applicant from consideration for a Certificate of Authority or revocation of the certificate if such certificate is already awarded.

PERSONAL QUALIFYING INFORMATION:

A. PERSONAL INFORMATION:

Name (Last	*(First)*	*(Middle Initial)*
Street Address (residence)		
City	*State*	*Zip Code*
Telephone # (Area Code)		
Business Name and Address		
City	*State*	*Zip Code*
Telephone # (Area Code)		
Date of Birth (Month/Day/Year)	*Place of Birth (County & State*	*Social Sec. #*
Current or Proposed position with the Proposed Independent Review Agent		

B. INDIVIDUAL EMPLOYMENT HISTORY.

Start with MOST RECENT employment and include employment for the last 10 years. A resume may be included but any additional information requested below and not contained in such a resume should be added. Photocopy and attach additional pages if necessary.

Name and address of Employer	Type of Business	Title of Position and Main Responsibilities	Starting Date	Termination Date	Reason for Termination

C. License History:

Type of License	Rate Received	Name and Address of Institution Granting License	Expiration Date

D. Education history (College and Subsequent Education) :

Name of Institution	Address	Dates of Attendance	Degree	Date Received

E. HISTORY OF ANY LEGAL ACTIONS:

YES	NO	Any "YES" answer requires a complete explanation
		Have you ever changed your name or used an alias?
		Have you ever been convicted of a felony ?
		Are there any criminal actions pending against you ?
		Have you been named as a defendant in any criminal or civil action in which fraud or breach of fiscal responsibility was an issue ?
		Have you ever been an owner, officer, trustee, management employee or controlling stockholder of an entity that while you occupied any such position: suffered the suspension or revocation of its certificate of authority or license to do business in any state, or was denied a certificate of authority, license or contract to do business in any state?

AFFILIATIONS OF HOLDING COMPANY OR PARENT ENTITY:

INSTRUCTIONS: In this section, affiliation includes serving as an officer, director, and member of the management staff, stockholder of 10% or more of the stocks or key advisor for health care operations.

1. For the past 10 years, have you owned or operated or been affiliated with any health care or health related operations?

   YES _____ NO _____

   If "yes" list the name(s) and address(es) of health care operation, your affiliation dates, the nature of the affiliation, the agency that licenses the health care operation, and the license number.

2. Are/were these health care operations in compliance with applicable laws and regulations during your affiliation?

   YES _____ NO _____

   If "no" provide a complete explanation of each violation, including the nature of the violation, the name and address of the agency enforcing the violation, the steps taken by the health care operation to remedy the violation, and indicate whether any suspension, revocation or accreditation has since been restored.

Personal Financial Involvement:

1. Financial support for the proposed External Review Organization
   Do you intend to provide capital for use in owning, organizing or operating the proposed External Review Organization?

   YES _____ NO _____

   If "yes" provide the following:

   a. Personal financial statement.
   b. Percent and value of the business you control
   c. Any additional information pertinent to determination of either the applicant's financial capabilities or the projects feasibility.

2. Transactions with the proposed External Review Organization or holding company.

   For this section, transaction is any business transaction of five hundred ($500) dollars or more that during any one fiscal year, represents 5% of the total annual operating expenses of a any parties to the transaction. Transactions include any sales or leasing of any property but do not include salaries paid to employees for services provided in the normal course of their employment.

   Have any transactions involving money, extension of credit, liens, notes, bonds or mortgages occurred or are such transactions anticipated between the proposed External Review Organization and you or any of your relatives or between the holding company and you or any of your relatives ?

   YES _____ NO _____

If "yes" provide information on the transaction, including the parties to the transaction, the type of transaction, the value of the transaction (dollar value and percent of operating costs), the percent interest rate, the reason for the transaction, and the method of payment.

External Review Agent Provider Listing:

For each clinical peer reviewer and medical director of the External Review Organization, complete the following information. Please identify potential ***CONFLICT of INTEREST*** *for each reviewer.*

NAME:	*LICENSE # :*	*STATE OF ISSUANCE:*	
STREET:	*CITY:*	*STATE:*	*ZIP:*
PRIMARY SPECIALTY:	*DATE Of CERTIFICATION EXPIRATION:*		
SUB-SPECIALTY:	*DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:*		

NAME:	*LICENSE # :*	*STATE OF ISSUANCE:*	
STREET:	*CITY:*	*STATE:*	*ZIP:*
PRIMARY SPECIALTY:	*DATE Of CERTIFICATION EXPIRATION:*		
SUB-SPECIALTY:	*DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:*		

NAME:	*LICENSE # :*	*STATE OF ISSUANCE:*	
STREET:	*CITY:*	*STATE:*	*ZIP:*
PRIMARY SPECIALTY:	*DATE Of CERTIFICATION EXPIRATION:*		
SUB-SPECIALTY:	*DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:*		

NAME:	*LICENSE # :*	*STATE OF ISSUANCE:*	
STREET:	*CITY:*	*STATE:*	*ZIP:*
PRIMARY SPECIALTY:	*DATE Of CERTIFICATION EXPIRATION:*		
SUB-SPECIALTY:	*DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:*		

NAME:	*LICENSE # :*	*STATE OF ISSUANCE:*	
STREET:	*CITY:*	*STATE:*	*ZIP:*
PRIMARY SPECIALTY:	*DATE Of CERTIFICATION EXPIRATION:*		
SUB-SPECIALTY:	*DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:*		

NAME:	*LICENSE # :*	*STATE OF ISSUANCE:*	
STREET:	*CITY:*	*STATE:*	*ZIP:*
PRIMARY SPECIALTY:	*DATE Of CERTIFICATION EXPIRATION:*		
SUB-SPECIALTY:	*DATE OF SUB-SPECIALTY CERTIFICATION EXPIRATION:*		

The above information is accurate and complete for all participating peer reviewers and the Medical Director of the External Review Organization.

____

CEO Signature

Sworn and subscribed to before me this _______Day of____________,20_____.

____________________________________*My commission expires*___________________

Notary Public

Conflict of Interest Attestation

To be executed by the CEO on behalf of the corporate entity, owners, officers, directors, medical director and management employees of the applicant.

For purposes of this attestation, "material familial interest" means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse, or sibling's spouse. "Material financial interest" means any financial interest more than five percent of total annual revenue or total annual income of an Independent Review Agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any independent review. The term material financial interest shall not include revenue received from a health care plan by an Independent Review Agent to conduct an independent review. "Material professional interest" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial interest with any expert or any officer or director of the organization.

I. Whereas, the applicant for certification as an Independent Review Agent shall not own or control, be owned or controlled by, or exercise common control with any of the following:
   1. a health carrier;
   2. a national, state, or local trade association of health carriers; or
   3. a national, state, or local trade association of health care providers; and

II Whereas, no Independent Review Agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any independent review, shall have any material professional affiliation, material familial affiliation, material financial affiliation, or other affiliation proscribed pursuant to regulation, in relation to an independent review, with any of the following:
   1. the health carrier that is the subject of the external review;
   2. any officer, director, or management employee of the health carrier that is the subject of the external review;
   3. the health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;
   4. the facility or institution at which the recommended health care service or treatment would be provided;
   5. the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review; or
   6. the covered person or the covered person's authorized representative; and

III. Whereas, the following organizations are not eligible for certification to conduct external reviews:
   1. professional or trade associations of health care providers;
   2. subsidiaries or affiliates of such provider associations;
   3. health carrier or health plan associations; and
   4. subsidiaries or affiliates of health plan or health carrier association

Now, therefore,_____in my capacity as Chief Executive Officer of the applicant ,
(name of Chief Executive Officer)

_____ do attest and affirm under penalty of perjury that _____
(applicant) (applicant)

has no disqualifying relationship as described in Section 1 above, as described in Section I above, and further, that neither_____ nor any of it owners, officers, directors, medical
(applicant)
director, management employees, or clinical peer reviewers currently employed or engaged have any material affiliation (as defined above) with any person or entity listed in Section II above except as indicated on the attached sheet(s) incorporated and made as part hereof; and further that _____is not
(applicant)
one of the types of organizations listed in Section III above.

I further do attest and affirm that I am familiar with the laws and regulations regarding external review in West Virginia and that _____will conform its conduct of external reviews to these laws and
(applicant)

regulations as they are now in effect or as they may change in the future.

I further do attest and affirm that any significant change in this application and any addition or deletion of an external review agent will go promptly reported to the Insurance Commission of West Virginia.

Name of
Chief Executive Officer_____
Signature Date

Sworn and subscribed to before me this _____day of_____,20_____.

_____ _____
Notary Public My commission expires